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Commenting on:

SB 357: An Act Concerning Copay Accumulator Programs and High Deductible Health Plans

SB 358: An Act Concerning Required Health Insurance Coverage for Breast Health Benefits

HB 5383: An Act Concerning Association Health Plans

HB 5386: An Act Concerning Health Insurance Coverage for Epinephrine Cartridge Injectors

My name is Wyatt Bosworth and I am assistant counsel for CBIA, the Connecticut Business & Industry Association. CBIA is Connecticut's largest business organization, with thousands of member companies, small and large, representing a diverse range of industries from across the state. Ninety-five percent of our member companies are small businesses, with less than 100 employees.

SB 357: AAC Copay Accumulator Programs and High Deductible Health Plans—SUPPORT

Last year, Governor Lamont signed into law Public Act No. 21-14 (SB 1003), An Act Prohibiting Certain Health Carriers and Pharmacy Benefits Managers from Employing Copay Accumulator Programs. In summary, the bill requires **every** individual or group health insurance policy in the state after January 1, 2022 to credit third-party discounts toward an individual or family's coinsurance, copayment, deductible or other out-of-pocket limits.

Given recent guidance from the Department of Health and Human Services (HHS), the public act in its current form is deeply problematic for the continued viability of high deductible health plans (HDHPs) tied with a

health savings account (HSA). In Connecticut, roughly 54% of private employees are enrolled in HDHPs in 2020, [1] many of which have an HSA component tied to the benefit plan.

The language adopted by this committee last year clearly runs counter to recent guidance issued by HHS. If language is not adopted to exempt HDHPs with HSAs from Public Act No. 21-14, tens of thousands of Connecticut employees may see their health plans shut down by the federal government.

On May 14, 2020, HHS issued Rule 85 FR 29164 (2021 NBPP Final Rule) that addressed whether drug manufacturer coupons must be applied towards the annual limitation on out-of-pocket costs. The rule arose after previous HHS guidance conflicted with a 2004 IRS notice that an individual in a HDHP HSA plan is responsible for paying the costs of any drug (taking into account the discount) until the deductible of any other health plan covering the individual is satisfied.[2]

Simply put, according to previous IRS guidance and Section 233 of the IRS Code, individuals and families enrolled in an HSA-compliant HDHP are not permitted to have medical expenses paid for by a third-party until the associated deductible and out-of-pocket limits are achieved. For example, the 2021 NBPP rule stated:

> *Since its enactment, section 223 of the Code has provided that individuals covered by an HDHP may not have medical expenses paid by other coverage prior to satisfying the deductible and remain eligible to contribute to an HSA (with certain limited exceptions, such as preventive care or disregarded coverage). There is no requirement that individuals covered by an HDHP exclusively pay for medical expenses they incur before meeting the deductible (and so, for example, family members may provide assistance as a gift to the individual, which may include paying for medical expenses on behalf of the*

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[1] Jamie Cattanach, High-Deductible Health Plans Continue to Grow in Popularity, but Are They Right for You? (Jan. 24, 2022) https://www.valuepenguin.com/high-deductible-health-plan-study

[2] Internal Revenue Bulletin: 2004-33 (Aug. 16, 2004) ("Q-9. May an individual who is covered by an HDHP and also has a discount card that enables the user to obtain discounts for health care services or products, contribute to an HSA? . . . . A-9. Yes. Discount cards that entitle holders to obtain discounts for health care services or products at managed care market rates will not disqualify an individual from being an eligible individual for HSA purposes if the individual is required to pay the costs of the health care (taking into account the discount) until the deductible of the HDHP is satisfied.").

> *individual).* ***However, the HDHP is not permitted to credit the deductible in a manner that does not reflect the actual cost of medical care to the individual.***[3]

Given that Public Act 21-14 prohibits HDHPs with HSAs to establish copay accumulator programs, the application of drug coupon cards toward an individual or family's deductible or out-of-pocket limit violates the federal tax code and recent HHS guidance.

The problem with including HSA-compliant HDHPs in copay accumulator bills has already surfaced in states across the country that adopted similar language to that of Public Act 21-14:

- **Illinois**: The U.S. Department of Treasury and Centers for Medicare and Medicaid Services confirmed with the Illinois Department of Insurance that applying drug discounts to an individual's cost-sharing requirements makes an individual ineligible to contribute to an HSA (note that the restriction does not apply to payments for any services that the Treasury recognizes as preventative care, such as insulin, nor does it apply to any cost-sharing incurred after the deductible has been reached). The Illinois Insurance Commissioner, for the 2022 plan year, issued a bulletin that prohibited all fully insured plans in the individual and small group market from being marketed as a qualified HDHPs on the exchange, and in the large group market and any off-exchange individual and small group plans, compliance with the copay accumulator bill would prohibit marketing as a qualified HDHP as well.[4]
- **Oklahoma**: While the state Department of Insurance issued a bulletin on October 29, 2021 stating that all HDHPs must comply with HB 2678 moving forward, the bulletin also stated that it is "actively engaging with the Legislature to seek clarification regarding the conflict between the state statute and federal requirements governing HSA eligibility."[5]

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[3] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, 84 FR 29164 (July 13, 2020). https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021 (emphasis added).

[4] Illinois Dep't of Insurance, Company Bulletin 2021-11 IMPORTANT NOTICE REGARDING 215 ILCS 134/30(d) (Aug. 25, 2021) https://www2.illinois.gov/sites/Insurance/Companies/CompanyBulletins/CB2021-11.pdf

[5] Oklahoma Insurance Department, Special Notice Regarding 36 O.S.1250.5 (18) (Oct. 29, 2021) https://www.oid.ok.gov/bulletin-no-lh-2021-05/

- **Kentucky:** Senate Bill 45 passed in 2021 and prohibits health plans and PBMs from excluding cost-sharing amounts covered by coupons, discounts, or vouchers when calculating a participant's total cost sharing. The Kentucky Department of Insurance issued guidance that the provisions of the bill only apply to the extent permitted by federal law and noted that the rules do not apply to HDHPs when paired with an HSA.[6]

Using the state of Illinois as a worst-case scenario example, Connecticut could receive enforcement guidance tomorrow if HSA-compatible HDHPs continued to comply with Public Act 21-14. If such enforcement was handed down, all HSA-compatible HDHPs in the state would not be permitted to advertise as a qualified HDHP and employees enrolled in those plans may lose access to contribute and spend HSA funds on qualified medical expenses. To avoid this scenario, CBIA urges the committee to exempt HSA-compatible HDHPs from Public Act 21-14.

SB 358: AAC Required Health Insurance Coverage for Breast Health Benefits—OPPOSE

HB 5386: AAC Health Insurance Coverage for Epinephrine Cartridge Injectors—OPPOSE

Year after year, Connecticut employers list healthcare costs as one of their top concerns. Through cost-sharing, business owners cover an average 76% of premiums on behalf of their employees. Connecticut has the sixth highest healthcare expenditures per enrollee in the country and that figure directly correlates to the number of state health benefit mandates.

Mandates drive up costs because with each new requirement, insurers must expand coverage to include additional services or devices. This increases the cost of health insurance premiums, and those increases are passed directly onto enrollees. Each year, Connecticut residents pay an additional $2,085.48 in premium costs because of the 68 health benefit mandates codified in law. These increases are detrimental to small employers

[6] Commonwealth of Kentucky Department of Insurance, BULLETIN 2021-002 https://insurance.ky.gov/ppc/Documents/2021-002%20New%20Legislation%20Bulletin.pdf ("Additionally, it should be noted that the provisions only apply to the extent permitted by federal law. Therefore, based on guidance from the Internal Revenue Service in IRS Notice 2004-50 Q&A-9, the provisions of the Act do not apply to the amount accumulated towards the deductible applied to high deductible health plans paired with a health savings account.").

(defined as under 50 FTE), who are not required to offer health insurance pursuant to the Affordable Care Act, but choose to do so.

Our members appreciate the importance of healthcare coverage and the role it plays in supporting a healthy workforce. However, with mandates, the cost outweighs the presumed benefits. This is why employers urge this committee to recontinue the Health Benefit Review Program, enacted in 2009 to authorize the Connecticut Insurance Department (CID) to conduct a cost-benefit analysis of any mandates at the request of the legislature (CGS sec. 38a-21).

The Health Benefit Review Program goes well beyond the fiscal note provided by the Office of Fiscal Analysis. This review includes: the portion of the population that would utilize the benefit, the extent to which the benefit is currently available, the extent to which coverage is already available, the level of public demand for the benefit, the impact the benefit would have on the availability of other benefits, the cost to carriers and employers, as well as the overall social implications of the mandate.

CBIA broadly opposes any healthcare mandate bills without a complete cost-benefit analysis being conducted prior to passage. Health benefit mandates pose an enormous cost to all Connecticut residents. The business community looks forward to working with this committee in an effort to lower healthcare costs, while maintaining the highest quality of care.

HB 5383: AAC Association Health Plans—SUPPORT

Every year, small businesses experience premium increases that make it incredibly difficult to offer their employees affordable coverage. Just last year alone, CID approved an average increase in the small group market of 6.7% (compared to a 5.6% increase in the individual market). Some businesses saw their premiums increase by as much as 13.97% in 2021.

Association health plans (AHPs) allow small businesses to band together to buy insurance, giving small employers economies of scale and large group status for rating and plan design purposes.

This is important because large group health plans enjoy greater savings due to design and underwriting flexibility that small group plans simply cannot achieve. Further, large group plans possess greater bargaining power with insurance carriers and can obtain administrative efficiencies that are unavailable to small groups and individuals.

However, to this date, CID has taken a strict approach to regulating AHPs. Under federal law, AHPs are Multi-Employer Welfare Arrangements and thus subject to regulation under both federal and state laws. Following a new rule promulgated by the Trump administration to expand AHP eligibility (which was recently struck down in federal court), CID issued Bulletin HC-123 in 2018 that required any small employer insured under a fully insured AHP in Connecticut to be rated as a small employer despite the fact that the sponsoring association has more than 50 employees.

This strict "look-through" provision rendered AHPs irrelevant in the state by preventing small employers from achieving a large group status under an AHP, and prevented the cost-saving plan designs that hundreds of Connecticut employers currently enjoy. HB 5383, if passed, effectively renders Bulletin HC-123 moot by authorizing fully insured AHPs "to the maximum extent permitted by federal law."

If/when Bulletin HC-123 is preempted by this bill, the association would have to prove they are a "bona fide group or association of employers" as defined under ERISA to achieve large group status. To satisfy this requirement, an association of employers must:

1. Have a commonality of interest unrelated to the provision of benefits;
2. Exercise control over the employee welfare benefit plan, in both form and in substance; and
3. Consist of employers with at least one common law employee.[7]

Once certified by the state Department of Labor, an AHP can offer fully insured large group coverage to association employer-members and their employees. However, despite the improved flexibility of plan design that large group status provides, the AHP must still abide by a number of federal requirements, including:

- Submitting M-1 and Form 5500 filings with the DOL;

[7] DOL Advisory Opinion 2005-12A.

- Complying with disclosure requirements of Title I of ERISA (I.e. summary plan descriptions, summary of material modifications, etc) and Summary Benefits and Coverage requirements;
- Covering preexisting conditions for any health benefit that coincides with an Essential Health Benefit;
- Covering pregnancy, childbirth, and related maternity and newborn medical conditions;
- Covering hospital stays of at least 48 hours in connection with childbirth and 96 hours for a Cesarean birth;
- Covering dependent children until their 26th birthday;
- Covering preventive care services with no out-of-pocket costs;
- Covering pre-existing conditions and prohibiting annual and lifetime spendings limits for any health; benefit that corresponds to an EHB;
- Having an internal and external appeals process regarding benefit determinations; and
- Complying with COBRA obligations.

Due to the fact states are the primary regulators of health insurance and have broad latitude to regulate fully insured AHPs, the state of Connecticut has the ability to require these AHPs to:

- Comply with benefit standards that otherwise apply to the individual and small group market;
- Meet the same solvency and governance standards as commercial carriers;
- Contribute to state guaranty funds to protect policyholders in the event of default;
- Submit and receive advance approval of marketing materials; or
- Submit to rigorous financial requirements or be placed in receivership if needed.

In summary, AHPs offer small employers access to the large group market. By joining the large group market, small employers can take advantage of less-expensive health plans that have a higher medical loss ratio (I.e. a lower percentage of premiums go to insurer profit and administrative costs), more flexible plan design and better bargaining power to negotiate better rates. However, even as a large group health plan, AHPs still have to abide by a number of federal and state level requirements regarding financial reporting, pre-existing conditions, and lifetime and annual spending limits. CBIA urges you to support this bill. Thank you.